Small Group Master Application – Oregon

For groups of 1-50 employees

PacificSource HEALTH PLANS

Employer Information

Legal Name of Group _____ Effective Date _____

DBA Name (appears on bills and ID cards) _____ SIC or NAICS Code _____

Physical Address Required (no PO Box) _____

City _____ State _____ ZIP _____ County _____

Mailing Address (if different than Physical Address) _____

City _____ State _____ ZIP _____ County _____

Federal Tax ID No. _____ Company Headquarters State _____ Nature of Business _____

Name(s) of All Owners and Partners _____

Form of Organization
(check all that apply)

- ☐ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Subchapter S-Corp
- ☐ Government
- ☐ Partnership
- ☐ Association
- ☐ Nonprofit ☐ C-Corp
- ☐ MEWA ☐ Church
- ☐ Union ☐ Trust

Group Contacts

Group Contact _____ Phone _____ Email _____ Fax _____

Group Contact _____ Phone _____ Email _____ Fax _____

Billing Contact _____ Phone _____ Email _____ Fax _____

Billing Contact _____ Phone _____ Email _____ Fax _____

Affiliates

Is your company affiliated with any other? ☐ Yes ☐ No **Will it be insured with PacificSource?** ☐ Yes, Common Ownership Form is attached ☐ No

Name of Affiliate(s) _____ No. of Employees _____

Address of Affiliate(s) _____ Should each affiliate be billed separately? ☐ Yes ☐ No

Current Insurance (Required if you had prior coverage)

Medical

Carrier _____

Policy No. _____

Term Date _____

Dental

Carrier _____

Policy No. _____

Term Date _____

Who was eligible for your prior dental plan?

☐ Children Only ☐ Adults and Children

Existing Workers' Compensation

Carrier _____

Policy No. _____

Medical Benefit Information

The medical policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the ACA for small groups. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Contact your agent or let your PacificSource representative know if you wish to purchase a stand-alone dental care product.

Please select no more than four plans for your group members to choose from. Need some guidance? Please contact your sales representative with questions.

☐ **Navigator** ☐ **Pathfinder** ☐ **SmartChoice** ☐ **Voyager**

- ☐ Platinum 500
- ☐ Gold 1000
- ☐ Gold 2000
- ☐ Gold 2500
- ☐ Gold 3500
- ☐ Silver 3000
- ☐ Silver 4500
- ☐ Silver 5500
- ☐ Silver 6500
- ☐ Bronze 8150
- ☐ Gold HSA 3000
- ☐ Silver HSA 3000
- ☐ Silver HSA 4500
- ☐ Silver HSA 5500
- ☐ Bronze HSA 6900

Voyager Only

- ☐ Standard Gold
- ☐ Standard Silver
- ☐ Standard Bronze

Dental Benefit Information

- ☐ Dental Choice 0-20-50 50-1000
- ☐ Dental Choice Plus 0-20-50 25-1000
- ☐ Dental Choice Plus 0-20-50 25-1500
- ☐ Dental Choice Plus 0-20-50 50-1000
- ☐ Dental Choice Plus 0-20-50 50-1500
- ☐ Dental Advantage Core
- ☐ Dental Advantage 20-20-50 1000
- ☐ Dental Advantage 20-20-50 1500
- ☐ Dental Advantage 0-20-50 1000
- ☐ Dental Advantage 0-20-50 1500
- ☐ Dental Advantage Plus 0-20-50 1000
- ☐ Dental Advantage Plus 0-20-50 1500
- ☐ Kids Dental Advantage 0-20-50 (for members through the age of 18)
- ☐ Kids Dental Advantage 20-40-50 (for members through the age of 18)
- ☐ Cosmetic Orthodontia (minimum enrollment requirements)

Billing Structure/SHOP Eligibility

Billing Structure: Tiered rates (based on family composition)

☐ Small Business Health Options Program (SHOP) enrollment. *If yes, please complete the state specific SHOP eligibility form.*

Employer Premium Contribution (The amount the employer will contribute towards the employee and dependent premium)

Medical: Employee _____ Dependent _____

Dental: Employee _____ Dependent _____

Eligibility

Probationary Waiting Period

☐ Date of hire (premium prorated first month)
☐ First of the month following Date of Hire
☐ First of the month following 30 days
☐ First of the month following 60 days
☐ 90 calendar days effective on 91st calendar day (premium prorated first month)
☐ Other _____

If the last day of the probationary period falls on the first day of the month, when will the new employee's eligibility be effective?

☐ Eligible that day
☐ Must wait until the first day of the following month or 91st day, whichever comes first (default if not marked)

Initial Enrollment: Will the probationary period be waived at initial enrollment? ☐ Yes ☐ No

Minimum Hours

How many hours per week must employees work to be eligible for coverage?

Hours per week _____

Eligible Members

Plan covers:

☐ Employee+spouse/domestic partner + children
☐ Employee only

HSA, HRA, FSA, COBRA Administration, or EAP

Check accounts your group has ☐ HSA ☐ HRA ☐ FSA ☐ COBRA Admin ☐ EAP Employer Contribution to HRA or HSA _____

Third Party Administrator Name _____ Phone _____

Mailing Address _____

City _____ State _____ ZIP _____ Email _____

People to Be Insured

1. _____ Total number of employees (full-time, part-time, owner, partner, principal, probationary, and waiver; exclude continuation)
2. _____ Total number of former employees currently on Continuation or Retiree with your group health plan (submit Employee Enrollment and Waiver Form)

A. _____ TOTAL NUMBER OF EMPLOYEES: Add numbers 1 and 2 above

3. _____ Total number of employees who do not qualify due to hourly requirement
4. _____ Total number of employees who do not qualify due to waiting period requirement
5. _____ Total number of employees waiving coverage due to other qualified coverage* (submit Employee Enrollment and Waiver Form)
   **Qualified Coverage: Employer Plan, Medicare, Medicaid, VA/Tricare, and Indian Health Service*
6. _____ Total number of employees not insured for reasons not stated above
   Please explain reason (e.g., classification not eligible, chose not to participate): _____

B. _____ TOTAL NUMBER OF EMPLOYEES NOT ENROLLING: Add numbers 3 through 6 above

C. _____ TOTAL NUMBER OF EMPLOYEES ENROLLING, including continuation: Subtract B from A above

SERVICE AREA: Do all employees reside within the PacificSource service area? ☐ Yes ☐ No If no, what state(s): _____

ERISA: Is your group comprised of employees of a government entity or church that is **NOT** subject to ERISA? ☐ Yes ☐ No

Medicare Coordination (TEFRA): Did you employ 20 or more employees each working day each of the 20 or more calendar weeks in the **current or preceding calendar year**? ☐ Yes ☐ No

COBRA: Did you employ 20 or more total employees (full-time, part-time, seasonal) at least 50% of your business days in the **preceding calendar year**? ☐ Yes ☐ No

Employees on continuation of coverage (COBRA, State or USERRA):

Are any enrolling members covered under continuation on this plan? ☐ Yes ☐ No

If yes, Employee Enrollment and Waiver Form must be submitted for each employee on continuation.

RETIREE: Is group coverage available to retirees: ☑ Yes ☐ No Is the group a local government (school, city, county)? ☑ Yes ☐ No

Approval is dependent on PacificSource Policy and Approval. If you offer health or dental coverage to your retirees, please attach the requirements and employer premium contribution if any.

Requirements—Must Be Submitted Prior to Policy Effective Date

- ☐ Group Master Application
- ☐ Copy of Sold Rates
- ☐ Member Employee Enrollment and Waiver Information
- ☐ Binder Payment (est. first month premium) *Refunded if coverage not effectuated*
- ☐ Electronic Funds Transfer Form, if you want PacificSource to withdraw the monthly premium from a bank account
- ☐ Common Ownership Form, if applicable
- ☐ Group Identification Form, if applicable

This is an application for group insurance. Under no circumstances will coverage be in force until the policy is issued by PacificSource and accepted by the employer. Once a policy is issued, the policy terms control in all cases.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

If you type your name below, you understand that you are electronically signing this document and agree your electronic signature is the legal equivalent of your manual signature on this application.

Group Representative (Printed) _____ **Title** _____

Group Representative Signature _____ **Date** _____

I, the undersigned producer for this group, affirm that the information provided on this application is complete and correct to the best of my knowledge.

Producer Name (Printed) _____ **PacificSource Producer Number** _____

Producer Signature _____ **Date** _____

Your Application Will Be Processed Soon

What happens next?

1. You'll get an email with information to help you administer the plan.
2. You'll get the contract and a Member Handbook in the mail.
3. We'll send your employees their ID cards.

If additional information is needed, a PacificSource Representative will contact you. Please keep a copy of this application for your records.

Discrimination Is Against the Law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PacificSource:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (888) 977-9299 or, for TTY users, (800) 735-2900, 7:00 a.m. to 5:00 p.m.

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, (888) 977-9299, TTY 711, fax (541) 684-5264, or email crc@pacificsource.com. Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the PacificSource Customer Service Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at OCRPortal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at HHS.gov/ocr/office/file/index.html.

Amharic	ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (888) 977-9299 (መስማት ለተሳናቸው: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (888) 977-9299 (رقم هاتف الصم والبكم: 711).
Bantu	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (888) 977-9299 (TTY: 711).
Cambodian	បើ ប្រយ័ត្ន៖ សិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (888) 977-9299 (TTY: 711)។
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (888) 977-9299 (TTY: 711)。

Cushite-Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (888) 977-9299 (TTY: 711).
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez (888) 977-9299 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (888) 977-9299 (TTY: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (888) 977-9299 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(888) 977-9299 (TTY:711) まで、お電話にてご連絡ください。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (888) 977-9299 (TTY: 711)번으로 전화해 주십시오.
Laotian	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (888) 977-9299 (TTY: 711).
Nepali	ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःशिुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (888) 977-9299 (टटिविाइ: 711) ।
Norwegian	MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring (888) 977-9299 (TTY: 711).
Pennsylvania Dutch	Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call (888) 977-9299 (TTY: 711).
Persian-Farsi	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با (888) 977-9299 (TTY: 711) تماس بگیرید.
Punjabi	ਧਆਿਨ ਦਓਿ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਚਿ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (888) 977-9299 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
Romanian	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (888) 977-9299 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (888) 977-9299 (телетайп: 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (888) 977-9299 (TTY–Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 977-9299 (TTY: 711).
Tagalog	UNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (888) 977-9299 (TTY: 711).
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (888) 977-9299 (TTY: 711).
Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (888) 977-9299 (телетайп: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (888) 977-9299 (TTY: 711).